

INTERNAL REVENUE BULLETIN



HIGHLIGHTS OF THIS ISSUE

Bulletin No. 2015-14
April 6, 2015

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

INCOME TAX

Rev. Rul. 2015-7, page 849.

Federal rates; adjusted federal rates; adjusted federal long-term rate and the long-term exempt rate. For purposes of sections 382, 642, 1274, 1288, and other sections of the Code, tables set forth the rates for April 2015.

Rev. Proc. 2015-25, page 848.

Guidance is provided to individuals who fail to meet the eligibility requirements of section 911(d)(1) of the Internal Revenue Code because adverse conditions in a foreign country preclude the individual from meeting those requirements. A current list of countries for tax year 2014 and the dates those countries are subject to the section 911(d)(4) waiver is provided.

EMPLOYEE PLANS

Notice 2015-28, page 848.

This notice extends the temporary nondiscrimination relief previously established in Notice 2014-54 for certain closed defined benefit pension plans (i.e., defined benefit plans that provide ongoing accruals but that have been amended to limit those accruals to some or all of the employees who participated in the plan on a specified date) for an additional year by applying the relief to plan years beginning before 2017 if the conditions of Notice 2014-54 are satisfied.

T.D. 9714, page 831.

This document contains final rules that amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code, and the Public Health Service Act related to limited wraparound coverage. Excepted benefits are generally exempt from the requirements that were added to those laws by the Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act.

EXCISE TAX

Notice 2015-17, page 845.

Notice 2015-17 provides transition relief from the assessment of excise tax under section 4980D for small employers (in particular, employers who are not applicable large employers) who reimburse or pay a premium for an individual health insurance policy for an employee. Notice 2015-17 also addresses the treatment for federal tax and for market reform purposes of arrangements reimbursing premiums of 2%-shareholder employees of S corporations. Finally, Notice 2015-17 addresses application of the market reforms to certain employer arrangements to fund Medicare premium payments or to provide a TRICARE-related health reimbursement arrangement (HRA).

T.D. 9714, page 831.

This document contains final rules that amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code, and the Public Health Service Act related to limited wraparound coverage. Excepted benefits are generally exempt from the requirements that were added to those laws by the Health Insurance Portability and Accountability Act and the Patient Protection and Affordable Care Act.

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned

against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.

This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.

This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.

To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.

This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

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Part I. Rulings and Decisions Under the Internal Revenue Code of 1986

T.D. 9714

**DEPARTMENT OF THE
TREASURY
Internal Revenue Service
26 CFR Part 54**

**DEPARTMENT OF LABOR
29 CFR Part 2590
Employee Benefits Security
Administration**

**DEPARTMENT OF HEALTH
AND HUMAN SERVICES
45 CFR Part 146
Amendments to Excepted
Benefits**

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Final rules.

SUMMARY: This document contains final regulations that amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code, and the Public Health Service Act to specify requirements for limited wraparound coverage to qualify as an excepted benefit. Excepted benefits are generally exempt from the requirements that were added to those laws by the Health Insurance Portability and Accountability Act and the Affordable Care Act.

DATES: These final regulations are effective on May 18, 2015.

FOR FURTHER INFORMATION

CONTACT: Amy Turner or Elizabeth Schumacher, Employee Benefits Security Administration, Department of Labor, at (202) 693-8335 (not a toll-free number); Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317-5500 (not a toll-free number); Jacob Ackerman, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (410) 786-1565. (not a toll-free number).

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws, may call the EBSA Toll-Free Hotline at 1-866-444-EBSA (3272) or visit the Department of Labor's website (<http://www.dol.gov/ebsa>). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov/ccio) and information on health reform can be found at www.HealthCare.gov.

SUPPLEMENTARY INFORMATION:

I. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, 110 Stat. 1936 added title XXVII of the Public Health Service Act (PHS Act), part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and chapter 100 of the

Internal Revenue Code (the Code), providing portability and nondiscrimination provisions with respect to health coverage. These provisions of the PHS Act, ERISA, and the Code were later augmented by other consumer protection laws, including the Mental Health Parity Act of 1996,¹ the Mental Health Parity and Addiction Equity Act of 2008,² the Newborns' and Mothers' Health Protection Act,³ the Women's Health and Cancer Rights Act,⁴ the Genetic Information Nondiscrimination Act of 2008,⁵ the Children's Health Insurance Program Reauthorization Act of 2009,⁶ Michelle's Law,⁷ and the Affordable Care Act.⁸

The Affordable Care Act reorganizes, amends, and adds to the provisions of part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.⁹ Section 715(a)(1) of ERISA and section 9815(a)(1) of the Code, as added by the Affordable Care Act, incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728.

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, respectively, generally do not apply to

¹Pub. L. 104-204, 110 Stat. 2944 (September 26, 1996).

²Pub. L. 110-343, 122 Stat. 3881 (October 3, 2008).

³Pub. L. 104-204, 110 Stat. 2935 (September 26, 1996).

⁴Pub. L. 105-277, 112 Stat. 2681-436 (October 21, 1998).

⁵Pub. L. 110-233, 122 Stat. 881 (May 21, 2008).

⁶Pub. L. 111-3, 123 Stat. 65 (February 4, 2009).

⁷Pub. L. 110-381, 122 Stat. 4081 (October 9, 2008).

⁸The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act, Public Law 111-152, was enacted on March 30, 2010. (These statutes are collectively known as the "Affordable Care Act".)

⁹The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan," as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

excepted benefits. Excepted benefits are described in section 2791 of the PHS Act, section 733 of ERISA, and section 9832 of the Code.

The parallel statutory provisions establish four categories of excepted benefits. The first category includes benefits that are generally not health coverage¹⁰ (such as automobile insurance, liability insurance, workers compensation, and accidental death and dismemberment coverage). The benefits in this category are excepted in all circumstances. In contrast, the benefits in the second, third, and fourth categories are types of health coverage but are excepted only if certain conditions are met.

The second category of excepted benefits is limited excepted benefits, which may include limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community based care. Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other, similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain health flexible spending arrangements (health FSAs).¹¹ To be excepted under this second category, the statute (specifically, ERISA section 732(c)(1), PHS Act section 2722(c)(1), and Code section 9831(c)(1)) provides that limited benefits must either: (1) be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of a group

health plan, whether insured or self-insured.¹²

The third category of excepted benefits, referred to as “noncoordinated excepted benefits,” includes both coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. In the group market, these benefits are excepted only if all of the following conditions are met: (1) the benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to any event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.¹³

The fourth category of excepted benefits is supplemental excepted benefits.¹⁴ Such benefits must be: (1) coverage supplemental to Medicare, coverage supplemental to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) or to Tricare, or similar coverage that is supplemental to coverage provided under a group health plan; and (2) provided under a separate policy, certificate, or contract of insurance.¹⁵

In 2004, the Departments of the Treasury, Labor, and HHS published final regulations with respect to excepted benefits (the HIPAA regulations).¹⁶ (Subsequent references to the “Departments” include all three Departments, unless the headings or context indicate otherwise.)

On December 24, 2013, the Departments published additional proposed regulations with respect to the second category of excepted benefits, limited excepted benefits (2013 proposed regulations).¹⁷ The 2013 proposed regulations proposed to: (1) eliminate the requirement that participants in self-insured plans pay an additional premium or contribution for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of the plan; (2) set forth the criteria under which employee assistance programs (EAPs) that do not provide significant benefits in the nature of medical care constitute excepted benefits; and (3) allow plan sponsors in certain limited circumstances to offer, as excepted benefits, coverage that wraps around certain individual health insurance coverage. The intent of limited wraparound coverage is to permit employers to provide certain employees, dependents, and retirees who are enrolled in some type of individual market coverage with overall coverage that is generally comparable to the coverage provided under the employers’ group health plan, without eroding employer-sponsored coverage.

After consideration of comments received on the 2013 proposed regulations, the Departments published final regulations regarding dental and vision benefits and EAP benefits on October 1, 2014 (2014 final regulations).¹⁸ In the 2014 final regulations, the Departments also stated their intent to publish regulations that addressed limited wraparound coverage in the future, taking into account the extensive comments received on this is-

¹⁰See 62 FR 16894, 16903 (Apr. 8, 1997), which states that these benefits are generally not health insurance coverage.

¹¹26 CFR 54.9831-1(c)(3)(v); 29 CFR 2590.732(c)(3)(v); 45 CFR 146.145(b)(3)(v).

¹²See the discussion in the 2014 final regulations concerning the application of these requirements to benefits such as limited-scope dental and vision benefits and employee assistance programs at 79 FR 59131 (Oct. 1, 2014).

¹³26 CFR 54.9831-1(c)(4); 29 CFR 2590.732(c)(4); 45 CFR 146.145(b)(4). See also Q7 in Affordable Care Act Implementation FAQs Part XI, available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html.

¹⁴On February 13, 2015, the Departments issued guidance to clarify whether insurance coverage that supplements group health coverage by providing additional categories of benefits (and does not also fill gaps in group health plan coverage for cost-sharing obligations, such as coinsurance or deductibles) can be characterized as an excepted benefit. See Affordable Care Act Implementation FAQs Part XXIII, available at <http://www.dol.gov/ebsa/faqs/faq-aca23.html> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Supplemental-FAQ_2-13-15-final.pdf.

¹⁵26 CFR 54.9831-1(c)(5); 29 CFR 2590.732(c)(5); 45 CFR 146.145(b)(5). The Departments issued additional guidance regarding supplemental health insurance coverage as excepted benefits. See EBSA Field Assistance Bulletin No. 2007-04 (available at <http://www.dol.gov/ebsa/pdf/fab2007-4.pdf>); CMS Insurance Standards Bulletin 08-01 (available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf); and IRS Notice 2008-23 (available at http://www.irs.gov/irb/2008-07_IRB/ar09.html).

¹⁶69 FR 78720 (Dec. 30, 2004).

¹⁷78 FR 77632 (Dec. 23, 2014).

¹⁸79 FR 59131 (Oct. 1, 2014).

sue.¹⁹ After consideration of comments on the 2013 proposed regulations, on December 23, 2014, the Departments published new proposed regulations with respect to limited wraparound coverage (2014 proposed regulations), which set forth five requirements under which limited benefits provided through a group health plan that wrap around either eligible individual insurance or coverage under a Multi-State Plan would constitute excepted benefits.²⁰ A description of the 2014 proposed regulations is set forth below, together with a summary of the comments received on the 2014 proposed regulations and an overview of these final regulations.

II. Overview of the Final Regulations

Under the 2014 proposed regulations, limited benefits provided through a group health plan that wrap around either (1) eligible individual health insurance, or (2) coverage under a Multi-State Plan (collectively referred to as “limited wraparound coverage”) could constitute excepted benefits, if five requirements were met. For this purpose, the 2014 proposed regulations defined “eligible individual health insurance” as individual health insurance coverage that is not a grandfathered health plan,²¹ not a transitional individual health insurance market plan,²² and does not consist solely of excepted benefits. The preamble to the 2014 proposed regulations acknowledged that, in States that elect to establish a Basic Health Program (BHP), certain low-income individuals (for example, those with household income between 133 percent and 200 percent of the Federal poverty level) who would otherwise qualify for a tax credit to obtain a qualified health plan through an Exchange would instead be enrolled in coverage through the BHP. The Departments invited comments on how an em-

ployer might make wraparound coverage available to BHP enrollees.²³

Comments addressing the BHP all supported permitting wraparound of BHP coverage. The Departments agree and, therefore, these final regulations permit limited wraparound coverage of BHP coverage in the same manner as limited wraparound coverage of eligible individual health insurance.

A. Covers additional benefits

The 2014 proposed regulations stated that limited wraparound coverage would have to be specifically designed to wrap around eligible individual health insurance or Multi-State Plan coverage. That is, the limited wraparound coverage would have to provide meaningful benefits beyond coverage of cost sharing under the eligible individual health insurance or Multi-State Plan coverage. The preamble to the 2014 proposed regulations provided examples, such as that limited wraparound coverage could provide coverage for expanded in-network medical clinics or providers, or provide benefits that are not essential health benefits (EHBs) and that are not covered under the eligible individual health insurance.²⁴ The preamble to the 2014 proposed regulations also provided that limited wraparound coverage would not be permitted to provide benefits solely under a coordination-of-benefits provision and could not be an account-based reimbursement arrangement.²⁵ Limited wraparound coverage that covers solely cost sharing would not be permissible, as stated in the preamble to the 2014 proposed regulations, because reduced cost sharing can be obtained by choosing an individual health insurance policy with a higher actuarial value (for example, a platinum plan with a 90 percent actuarial value).²⁶ The Departments invited comment on safe harbors standardizing the

benefits in the limited wraparound coverage that could be established.

Many commenters requested additional clarity on the type of benefits that could be offered as meaningful benefits in limited wraparound coverage. Suggestions included reimbursement for the full cost of primary care, the cost of prescription drugs not on the formulary of the primary plan, ten physician visits per year, services considered to be provided out-of-network by the primary plan, access to onsite clinics or specific health facilities at no cost, or benefits targeted to a specific population (such as coverage for certain orthopedic injuries), home health coverage, or coverage of other benefits that are not covered EHBs under the primary plan. The Departments consider all of these examples to qualify as additional, meaningful benefits under this first requirement to be limited wraparound coverage that qualifies as excepted benefits. As discussed further below, the Departments reiterate that limited wraparound coverage that is an excepted benefit cannot be an account-based mechanism and instead must be a risk-sharing product that covers a defined package of services.

B. Limited in amount

For the second requirement to be limited wraparound coverage that qualifies as excepted benefits, the Departments proposed that the limited wraparound coverage be limited in amount. Specifically, the 2014 proposed regulations provided that the annual cost of coverage per employee (and any covered dependents) under the limited wraparound coverage could not exceed the maximum annual contribution for health FSAs (which was \$2,500 in 2014), indexed in the manner prescribed under Code section 125(i)(2) (which amounts to \$2,550 for 2015), and the cost of coverage would include both employer

¹⁹79 FR 59131 (Oct. 1, 2014).

²⁰79 FR 76931 (Dec. 23, 2014).

²¹See section 1251 of the Affordable Care Act, 29 CFR 2590.715–1251, and 45 CFR 147.140.

²²As described in CMS Insurance Standards Bulletin (March 5, 2014) available at: <http://www.cms.gov/CIIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf>.

²³79 FR 76935, footnote 32.

²⁴79 FR 76935

²⁵79 FR 76936

²⁶*Id.*

and employee contributions towards coverage and be determined in the same manner as the applicable premium is calculated under a COBRA continuation provision. The preamble to the 2014 proposed regulations stated that the bright-line limitation was intended to be simpler to administer than a cap of 15 percent of the cost of the plan sponsor's primary coverage as set forth in the 2013 proposed regulations.

Many comments stated that the limits on the amount should be higher so that individuals eligible for the limited wrap-around coverage would not experience gaps in coverage. Some commenters suggested that the Departments consider an alternative, referencing the higher health savings account (HSA) limits, which are \$3,350 for individual coverage and \$6,650 for families in 2015, indexed annually. Others suggested the Departments set the limit as the greater of: the maximum permitted annual salary reduction towards a health FSA (as was set forth in the 2014 proposed regulations), or a percentage of the cost of coverage under the primary plan (as was set forth in the 2013 proposed regulations).

These final regulations adopt the last suggestion. Either the dollar or percent limitation would satisfy the Departments' objective of ensuring that the limited wrap-around coverage provides a limited benefit, as required by the statute, and be similar to other limited excepted benefits (that is, dental benefits, vision benefits, long term care, nursing home care, home health care, community-based care, or health FSAs as described in 26 CFR 54.9831-1(c)(3); 29 CFR 2590.732(c)(3); 45 CFR 146.145(b)(3)). The percentage, as in the 2013 proposed regulations, is 15 percent of the cost of coverage under the primary plan.

The final regulations do not adopt the suggestion to use much higher limits on the cost of coverage (for example, the HSA limits). Too large a benefit that is not limited in scope (*c.f.*, limited-scope dental and vision excepted benefits) would not constitute a "similar, limited benefit" un-

der ERISA section 733(c)(2), PHS Act section 2791(c)(2), or Code section 9832(c)(2).

The Departments also received requests for clarification regarding the administration of the second requirement (that is, that the limited wrap-around coverage be limited in amount). Some comments requested that the determination of the cost of coverage be permitted to be made on an aggregate basis in advance of each plan year by an actuary, and not based on actual experience of the group or any individual during the plan year. This approach is precisely the approach that was intended by the Departments. As stated earlier, to qualify as excepted benefits, the limited wrap-around coverage could not be an account-based reimbursement arrangement. That is, the coverage must include a risk-sharing element. As such, making a determination regarding the cost of coverage must occur on an aggregate basis. Moreover, to the extent this determination for a given plan year is made on sound actuarial principles that are appropriately documented, the actual experience of the group or any individual during the plan year would not be a factor in determining the cost of coverage for that plan year (although it could impact future years by providing additional information on which the actuarial estimate of the cost of coverage for future years would be based). The final regulations include this clarification.

C. *Nondiscrimination*

Under the 2014 proposed regulations, the third requirement for limited wrap-around coverage to qualify as excepted benefits related to nondiscrimination. Specifically, the Departments proposed three sub-requirements relating to nondiscrimination. First, the wrap-around coverage could not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (as incorporated into section 715 of ERISA and section 9815 of the Code) and implementing regulations.²⁷ Second, the wrap-

around coverage could not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual), consistent with the requirements of section 702 of ERISA, section 9802 of the Code, and section 2705 of the PHS Act (as incorporated into section 715 of ERISA and section 9815 of the Code) and implementing regulations.²⁸ Finally, neither the primary group health plan coverage nor the limited wrap-around coverage could fail to comply with section 2716 of the PHS Act (as incorporated into section 715 of ERISA and section 9815 of the Code) or fail to be excludible from income with respect to any individual due to the application of section 105(h) of the Code (as applicable). These final regulations adopt the approach outlined in the 2014 proposed regulations.

The Departments received two comments on this third requirement. One commenter inquired as to the potential interaction between excepted benefits and the excise tax on high cost employer-sponsored health coverage under Code section 4980I. The Treasury and the IRS issued Notice 2015-16 on February 23, 2015 describing potential approaches with regard to a number of issues under Code section 4980I and inviting comments by May 15, 2015. Issues relating to Code section 4980I will be addressed as part of that rulemaking. Another commenter requested that the Departments consider "modernizing" the nondiscrimination provisions under Code section 105(h) and section 2716 of the PHS Act relating to prohibiting discrimination in favor of highly compensated employees. The Departments are considering this suggestion and other comments previously received for purposes of future guidance relating to these provisions.

D. *Plan eligibility requirements*

The fourth requirement to qualify as excepted benefits concerned plan eligibility requirements. First, under the 2014 proposed regulations, individuals eligible

²⁷29 CFR 2590.715-2704 and 45 CFR 147.108. See also Q2 in Affordable Care Act Implementation FAQs Part XXII, available at <http://www.dol.gov/ebsa/faqs/faq-aca22.html> and <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf> regarding the prohibition against offering employees with high claims risk a choice between enrollment in its standard group health plan or cash.

²⁸26 CFR 54.9802-1, 29 CFR 2590.702, and 45 CFR 146.121.

for the limited wraparound coverage could not be enrolled in excepted benefit coverage that is a health FSA. One commenter suggested permitting dual enrollment in limited wraparound coverage and health FSA coverage. However, as described earlier, the Departments are using their discretion under ERISA section 733(c)(2), PHS Act section 2791(c)(2), and Code section 9832(c)(2) to define “other similar, limited benefits” as excepted benefits and do not adopt this suggestion. To ensure that wraparound coverage is a limited benefit, like health FSAs, the Departments do not intend to allow plan sponsors to combine multiple excepted benefits into an arrangement that functions as a material substitute for primary group health plan coverage and still be exempt from the health market reforms.

Under the 2014 proposed regulations, as part of the fourth requirement for limited wraparound coverage to constitute excepted benefits, coverage would be required to comply with one of two alternative sets of standards relating to eligibility and benefits: one set of plan eligibility requirements for wraparound benefits offered in conjunction with eligible individual health insurance (or BHP coverage) for persons who are not full-time employees, and a separate set of standards for coverage that wraps around certain Multi-State Plan coverage. As described further below, limited wraparound coverage for persons who are not full-time employees is intended for employers that are generally offering affordable, minimum value coverage to their full-time workers but want to offer an additional limited benefit to their part-time workers. Limited wraparound coverage offered in conjunction with a Multi-State Plan is intended for employers that were offering reasonably comprehensive coverage prior to the promulgation of these final rules, and wish to offer limited wraparound coverage while still contributing roughly the same total amount toward their employees’ health benefits.

1. Limited wraparound coverage offered in conjunction with eligible individual health insurance (or BHP coverage) for persons who are not full-time employees

As under the 2014 proposed regulations, limited coverage that wraps around eligible individual health insurance (or

BHP coverage) for an individual who is not a full-time employee is required to satisfy three standards relating to plan eligibility.

i. Employer obligations with respect to full-time employees

First, for each year that wraparound coverage is offered, the employer that is the sponsor of the plan offering wraparound coverage, or the employer participating in a plan offering wraparound coverage, must offer to its full-time employees coverage that: (1) is substantially similar to coverage that the employer would need to offer to its full-time employees in order not to be subject to a potential assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions were applicable (that is, substantially similar to an offer of minimum essential coverage (as defined in Code section 5000A(f)) to at least 95 percent of its full-time employees (or to all but five of its full-time employees, if five is greater than five percent of its full-time employees)); (2) provides minimum value (as defined in section 36B(c)(2)(C)(ii) of the Code); and (3) is reasonably expected to be affordable (permitting use of the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). The preamble to the 2014 proposed regulations stated that, if a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose necessary information regarding their coverage offered and affordability information to the plan or issuer, the plan or issuer could rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary.

Several commenters requested that, in the context of small employers and multiemployer plans, there be an exemption from the requirement that, to be considered excepted benefits, the employer offer to its full-time employees coverage that is substantially similar to coverage that the employer would need to offer pursuant to Code section 4980H(a). However, these final excepted benefits regulations are designed to allow plan sponsors an option to offer additional workers health coverage

comparable to that which they already offer, rather than to serve as a substitute for primary coverage.

Other commenters asked the Departments to clarify that any Code section 4980H-related requirements are met in instances in which the employer has no full-time employees. These final regulations clarify that, in the event that the employer has no full-time employees, but the plan covers retirees (and their dependents), or covers part-time employees (and their dependents), the requirements to provide coverage that is substantially similar to coverage that the employer would need to offer to its full-time employees in order not to be subject to a potential assessable payment section 4980H(a) of the Code, that provides minimum value, and that is reasonably expected to be affordable, are all considered satisfied.

ii. Limited eligibility

Second, eligibility for the limited wraparound coverage must be limited to employees who are not full-time employees (and their dependents), or who are retirees (and their dependents). In the preamble to the 2014 proposed regulations, the Departments stated that “full-time employees” would be employees who are reasonably expected to work at least an average of 30 hours per week. Plans and issuers would not be required to define “full-time employees” strictly in accordance with the rules of Code section 4980H, but employers could rely on the Code section 4980H definition, or any reasonable interpretation of who is reasonably expected to work an average of 30 hours a week, for purposes of this provision. The Departments invited comment on this approach.

Some commenters argued that plan sponsors should be able to offer limited coverage that wraps around eligible individual health insurance to full-time employees. The Departments do not adopt this change. A rationale for treating the wraparound coverage as an excepted benefit is that recipients will be able to use this limited type of coverage in conjunction with individual coverage purchased through an Exchange without being disqualified from claiming the premium tax

credit. This may be attractive to employers as a means of providing some health coverage to employees who may not otherwise have been offered coverage, such as part-time employees or retirees. However, this is not intended to incentivize or permit employers to fail to offer minimum essential coverage to full-time employees, a population to whom employers have typically offered coverage.

One commenter sought clarification that plan sponsors offering limited wrap-around coverage may rely on a determination of full-time employee status at the time of enrollment. The Departments agree that employers offering limited wrap-around coverage will make determinations based on the expected status of an employee in the future as a part-time employee versus full-time employee. Accordingly, the final regulations include a clarification that this standard is met if it is reasonably determined at the time of enrollment that the employee will on average work fewer than 30 hours per week during the plan year. Moreover, for purposes of administering the premium tax credit under section 36B of the Code, if it is reasonably determined at the time of enrollment that the employee will on average work fewer than 30 hours per week during the plan year and therefore the employee is offered limited coverage that wraps around eligible individual health insurance, but the employee later during the coverage period meets the definition of a full-time employee, the coverage will not fail to be excepted benefits and the employee will not become ineligible for premium tax credits for the remainder of the plan year solely because the original reasonable determination proves incorrect. Whether, to be reasonable, that determination would need to be changed for future plan years will depend on all the facts and circumstances.

Several commenters sought clarification regarding the definition of “dependent.” Specifically, commenters asked whether the term “dependent” includes “spouses” (as the term is defined under 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 for purposes of chapter 100 of the Code, part 7 of ERISA, and

title XXVII of the PHS Act), or whether it is limited to “dependent children” (as the term is defined under Code section 4980H and its implementing regulations). These final regulations clarify that, for purposes of excepted benefits, the term “dependent” is defined by reference to the definitions section governing the market reforms (that is, 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103) and not the employer shared responsibility provisions under Code section 4980H and its implementing regulations. Accordingly, spouses may qualify as dependents to the extent they are eligible for coverage under the terms of the limited wrap-around coverage. Moreover, some commenters sought clarification as to whether a plan could permit enrollment of a spouse beneficiary without enrollment of an employee participant. While nothing in these final regulations, nor any other provision of ERISA, the Code, or the PHS Act requires plans to enroll spouse beneficiaries for coverage (other than COBRA coverage) if the participant does not enroll, nothing in these provisions prohibits plans from enrolling such a spouse if plans choose to do so.²⁹

iii. Offer of other group health plan coverage

Third, under the 2014 proposed regulations, other group health plan coverage, not limited to excepted benefits, would be required to be offered to the individuals eligible for the wrap-around coverage. Only individuals eligible for other group health plan coverage could be eligible for the wrap-around coverage.

Some commenters contended that plan sponsors should not be required to offer other group health plan coverage to individuals who are not full-time employees. This provision does not require employers to offer group health plan coverage to workers who are not full-time employees but it does limit the ability to offer the wrap-around coverage only to workers otherwise eligible for other group health plan coverage. That is because this provision is not intended to create an opportunity or incentive for employers to discon-

tinue providing group health plan coverage and to encourage its employees to obtain coverage through the Exchange subsidized through the premium tax credit while still receiving meaningful employer-provided health benefits. Further, the same standard is applied in order for a health FSA to be an excepted benefit, and this provision in the final regulation is intended to allow employers to offer a limited benefit, similar to a health FSA.

2. Limited wraparound coverage offered in conjunction with Multi-State Plan coverage

For limited coverage that wraps around Multi-State Plan coverage, four requirements would be required to be met under the 2014 proposed regulations.

i. OPM review and approval

The first of the four standards would require that the limited wrap-around coverage be specifically designed and approved by the Office of Personnel Management (OPM) to provide benefits in conjunction with coverage under a Multi-State Plan authorized under section 1334 of the Affordable Care Act. Several comments sought clarification as to whether OPM would be designing limited wrap-around coverage, or whether that would more appropriately be the role of the plan sponsor or health insurance issuer. These final rules include a modification to clarify that OPM would not design limited wrap-around coverage. Instead, OPM’s role would be to review and approve such coverage. Moreover, as indicated in the preamble to the 2014 proposed regulations, with respect to the maintenance of effort standard (discussed below), OPM’s role is to ensure that group health plans and health insurance issuers offering Multi-State Plan wrap-around coverage have a reasonable process in place for assuring employers meet the criteria set forth in these regulations for excepted benefits.

ii. Maintenance of effort

The 2014 proposed regulations provided that the employer would have had to

²⁹See ERISA section 601, Code section 4980B and PHS Act section 2201, which requires enrollment of qualified beneficiaries (including spouses) after a loss of coverage in connection with a qualifying event.

offer coverage in the plan year that began in 2014 that is substantially similar to coverage that the employer would need to have offered to its full-time employees in order to not be subject to an assessable payment under the employer shared responsibility provisions of section 4980H(a) of the Code, if such provisions had been applicable. In addition, in the plan year that began in 2014, the employer would have had to have offered coverage to a substantial portion of full-time employees that provided “minimum value” (as defined in section 36B(c)(2)(C)(ii) of the Code) and was affordable (applying the safe harbor rules for determining affordability set forth in 26 CFR 54.4980H-5(e)(2)). Finally, for the duration of the pilot program (described later in this preamble), the employer’s annual aggregate contributions for both primary and limited wraparound coverage must be substantially the same as the employer’s aggregate contributions for coverage offered to full-time employees in 2014. The Departments stated in the preamble that they were considering interpreting this “substantially the same” condition as a percentage (for example, 80 or 90 percent) and potentially applying it on a per-worker basis to allow for fluctuations in an employer’s workforce.

Citing that some employers may have made changes to their coverage in 2014 because Exchange coverage was first available in 2014, several commenters requested that plan sponsors be permitted to use either 2013 or 2014 as the base year for this maintenance of effort requirement set forth in these second and third requirements for limited coverage that wraps around Multi-State Plan coverage. These final regulations adopt this suggestion.

Other comments stated that an employer’s annual aggregate contribution toward primary and limited wraparound coverage should include any assessable payments under Code section 4980H owed by the employer. An applicable large employer may become subject to an assessable payment if it fails to offer minimum essential coverage to its full-time employees and one or more of those employees obtains a premium tax credit, or it fails to provide a full-time employee minimum essential coverage that provides minimum value and is affordable for that employee and

that employee obtains a premium tax credit. In neither case does the payment of an assessable payment provide coverage to the employee or otherwise assist that employee in obtaining coverage. Nor does the fact that the failure to provide coverage may permit the employee to obtain the premium tax credit mean that the resulting fee is contributing toward that employee’s health coverage. The final regulations, therefore, do not make this change.

Some comments sought clarification regarding whether the employer’s annual aggregate contributions for both primary and limited wraparound coverage must be substantially the same as the employer’s aggregate contributions for coverage offered to full-time employees in 2013 or 2014. Some requested OPM be given discretion to determine whether the maintenance of effort standard has been met by each employer. Others requested a threshold of 60 percent in determining whether this standard has been met. Many factors, including fluctuations in workforce size, cost of coverage, and employer contributions towards other fringe benefits may affect employer contributions from year to year. The final regulations retain the standard set forth in the 2014 proposed regulations that the employer’s annual aggregate contributions for both primary and limited wraparound coverage must be substantially the same as the employer’s aggregate contributions for coverage offered to full-time employees in 2014 (or 2013). For this purpose, the Departments consider this “substantially the same” condition to be met if contributions were at least 80 percent of contributions made in 2013 or 2014, applied on an average, full-time worker basis (to allow for fluctuations in an employer’s workforce). OPM may make a finding, based on all the facts and circumstances, that other employer contribution arrangements also meet this standard. OPM may provide additional guidance (such as examples and safe harbors) in the future.

As with coverage that wraps around eligible individual health insurance (or that wraps around Basic Health Plan coverage), commenters asked the Departments to clarify that any Code section 4980H-related requirements are met in instances in which the employer has no full-time employees. These final regula-

tions adopt a parallel clarification for coverage that wraps around Multi-State Plan coverage as for coverage that wraps around eligible individual health insurance (or that wraps around Basic Health Plan coverage). That is, while these final regulations do not permit new employers to provide wraparound coverage as an expected benefit, these final regulations clarify that, in the event that the employer has no full-time employees, but the plan covers retirees (and their dependents), or covers part-time employees (and their dependents), the requirements that, in the plan year that began in 2013 or 2014, the employer would have had to have offered coverage to a substantial portion of full-time employees that provided minimum value and was affordable is met, as is the requirement that, for the duration of the pilot program, the employer’s annual aggregate contributions for both primary and limited wraparound coverage must be substantially the same as the employer’s aggregate contributions for coverage offered to full-time employees in 2013 or 2014.

For purposes of administering this provision with respect to limited wraparound coverage offered in conjunction with Multi-State Plan coverage, the Departments had proposed that the term “full-time employee” means a “full-time employee” as defined in 26 CFR 54.4980H-1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in 26 CFR 54.4980H-1(a)(26)). Moreover, if a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose necessary information regarding their coverage offered and contribution levels for 2013 or 2014 to the plan or issuer, the plan or issuer may rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary. Consistent with the reporting and evaluation criteria described later in this preamble, the Departments stated that OPM may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

E. Reporting

The fifth and final requirement for limited wraparound coverage to qualify as excepted benefits under the 2014 proposed regulations is a reporting requirement, for group health plans and group health insurance issuers, as well as group health plan sponsors. The final regulations adopt the approach outlined in the 2014 proposed regulations.

A self-insured group health plan, or a health insurance issuer offering or proposing to offer Multi-State Plan wraparound coverage, would report to OPM, in a form and manner specified in OPM guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements of this section.

In addition, the plan sponsor of any group health plan offering any type of limited wraparound coverage would report to HHS, in a form and manner specified in guidance, information HHS reasonably requires to determine whether the exception for limited wraparound coverage is allowing plan sponsors to provide workers with comparable benefits whether enrolled in minimum essential coverage under a group health plan offered by the plan sponsor, or enrolled in eligible individual health insurance, BHP coverage, or Multi-State Plan coverage, with additional limited wraparound coverage offered by the plan sponsor, without causing an erosion of coverage.

Commenters requested that there be coordination of any reporting requirements with existing reporting requirements and some made specific suggestions regarding data elements that should be required for reporting. The Departments agree with the principle of non-duplication and will seek comment on any new reporting requirements through the process established by Paperwork Reduction Act of 1995.

F. Pilot Program With Sunset Date

Under the 2014 proposed regulations, limited wraparound coverage would be permitted under a pilot program for a limited time. Specifically, this type of wraparound coverage could be offered as ex-

cepted benefits if it is first offered no later than December 31, 2017, and ends on the later of: (1) the date that is three years after the date wraparound coverage is first offered; or (2) the date on which the last collective bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered (determined without regard to any extension agreed to after the date the wraparound coverage is first offered). The 2014 proposed regulations invited comments on this time frame for applicability, including whether the Departments should have the option to provide for an earlier termination date.

Many commenters cited uncertainty and the lack of lead time as negatively impacting full utilization of the pilot program and requested a longer implementation period. The Departments agree that the timing for publication of these final rules makes 2015 plan year implementation impossible or impracticable for most plans. Accordingly, these final rules specify that wraparound coverage could be offered as excepted benefits if the coverage is first offered no earlier than January 1, 2016 and no later than December 31, 2018. The end date is unchanged from the proposal, that is the later of: (1) the date that is three years after the date wraparound coverage is first offered; or (2) the date on which the last collective bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered (determined without regard to any extension agreed to after the date the wraparound coverage is first offered).

III. Economic Impact and Paperwork Burden

A. Summary

As discussed in detail above, these regulations amend the definition of “limited excepted benefits” in the group market to provide plan sponsors with two options to offer limited wraparound coverage to certain individuals. Under the first option, a plan sponsor could offer limited benefits provided through a group health plan that wraps around eligible individual health insurance to employees who are not full-time employees (and their dependents), or who are retirees (and their dependents). For this purpose, full-time employees are

employees who are reasonably expected to work at least an average of 30 hours per week. Under the second option, the limited wraparound coverage that satisfies the requirements outlined in the regulations must be approved by OPM and be offered in conjunction with Multi-State Plan coverage authorized under section 1334 of the Affordable Care Act. Under the first option, the limited benefits would also be permitted to wrap around the Basic Health Program authorized under section 1331 of the Affordable Care Act.

B. Executive Orders 12866 and 13563—Departments of Labor and HHS

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, and public health and safety effects; distributive impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a regulation: (1) having an annual effect on the economy of \$100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local, or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order. OMB has determined that the action is significant within the meaning of section 3(f)(4) of Executive Order 12866, and the Departments accordingly provide the following assessment of its potential benefits and costs.

The Departments recognize that many plan sponsors provide comprehensive health benefits to their workers. One objective of the Affordable Care Act is to allow individuals with comprehensive health insurance plans to maintain their current level of benefits. Some employers are interested in offering wraparound coverage to employees who are enrolled in a Multi-State Plan authorized under section 1334 of the Affordable Care Act or to part-time employees. These regulations provide two options to employers that clarify the circumstances under which plan sponsors can provide to their employees such limited wraparound coverage that qualifies as an excepted benefit.

The cost (and Federal budget impact³⁰) of these final regulations is difficult to quantify. The Departments solicited comments in the regulatory impact analysis section of the preamble to the 2014 proposed regulations. Comments were invited generally and on specific questions, including: To what degree, if any, might this regulation increase employers' propensity to provide health insurance? To what extent, if any, this proposed regulation could affect plan sponsors' decision making? Are there any particular sectors of the economy in which employers will be more or less inclined to pursue wraparound coverage programs?

Comments were also invited on the effects of the proposal and the Departments requested detailed data that would inform the following questions: What will be the impact of limiting the cost of the wraparound coverage to \$2,500 per employee (and any covered dependents)? How many employers offer coverage that provides minimum value and is affordable for a substantial portion (under the first option) or 95 percent (under the second option) of employees who are eligible for coverage? To what extent would premiums for comprehensive health coverage change in the presence and absence of this rule?

No specific data were received in response to this solicitation, although several commented that limited conditions

under which wraparound coverage could be offered were overly restrictive and made it of limited use. Others commented that the uncertainty of the life span of a time-limited pilot program would minimize uptake of the offering of limited wraparound coverage.

These final regulations generally implement the 2014 proposed regulations with marginal change, as discussed above. Both options are designed so that wraparound coverage could not replace employer-sponsored primary group coverage. Under the individual health insurance wraparound option, the employer also must offer other group health coverage that is not limited to excepted benefits and provides minimum value to the class of participants offered the wraparound coverage by reason of their employment. Only individuals who are not full-time employees and who are eligible for other group health plan coverage may be eligible for the wraparound coverage. Also, the employer coverage must substantially satisfy the employer shared responsibility provisions of Code section 4980H(a), and the coverage would have to be affordable for at least 95 percent of full-time employees.

Under the Multi-State Plan wraparound option, the employer would have to offer coverage in the plan year beginning in 2013 or 2014 that would have substantially satisfied the employer shared responsibility provisions of Code section 4980H(a) if the provision had been applicable, provided minimum value, and been affordable for a substantial portion of its full-time employees.³¹ The employer's annual contributions for both its primary and wraparound coverage must be substantial.

The final regulations permit limited wraparound coverage to be excepted benefits if initially offered between January 1, 2016 and December 31, 2018, and continuing for the longer of three years or the date on which the last collective bargaining agreement relating to the group health plan terminates. In addition, the maximum benefit cannot exceed the greater of the annual health FSA contribution limit (\$2,550 for 2015), indexed; or 15 percent

of the firm's primary plan cost. In the 2014 proposed regulations the maximum benefit was the annual health FSA contribution limits (\$2,550 for 2015), indexed.

As with the 2014 proposed regulations, the decision to offer the limited wraparound coverage remains optional. There is greater administrative complexity associated with the wraparound coverage than primary coverage alone or primary coverage plus a health FSA which offers similar benefits. Given a choice, some plan sponsors may choose to increase the affordability of their primary coverage rather than offer limited wraparound coverage. Some plan sponsors may not have that choice: the employers may not be in a financial position to make their primary health plans affordable to more workers, let alone contribute to wraparound coverage. Employers may also continue to simply not provide employees with affordable, minimum value coverage, allowing their workers to purchase coverage and potentially qualify for premium tax credits through an Exchange with no additional wraparound benefit, and these employers would continue to make any employer shared responsibility payments as applicable, resulting in no additional cost to the employer or the Federal government.

The option to offer limited wraparound coverage would not encumber any currently existing means by which employers can provide comprehensive health insurance coverage to their employees in compliance with the Affordable Care Act. Rather, it would clarify two additional, alternative means of doing so.

For the foregoing reasons, the Departments have reached the conclusion that the impact of the benefits, costs, and transfers will be limited. The Departments do not expect many plans to offer limited wraparound coverage, and will monitor usage and impact during the pilot program through reporting, as discussed above.

³⁰As with other group health coverage, employer contributions to the limited wraparound coverage would be excluded from employee income for tax purposes. Similar to the cost of the proposal, the budget implications of adding limited wraparound coverage as a form of excepted benefits depends on the number of employers that elect either option and the number of employees that in turn receive it.

³¹The substantial level was included to help minimize the implications for the primary plan's risk pool by preventing a large number of low-wage workers from leaving the primary plan for Exchange coverage.

*C. Paperwork Reduction Act—
Department of Labor and Department of
the Treasury*

These final regulations are not subject to the requirements of the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. section 3501 et seq.), because it does not contain a collection of information as defined in 44 U.S.C. section 3502(3).

*D. Paperwork Reduction Act—
Department of HHS*

The final rule is not subject to the requirements of the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. section 3501 et seq.), because it does not contain a collection of information as defined in 44 U.S.C. section 3502(3). An analysis under the PRA will be conducted in the future for any future guidance establishing a collection of information related to the rule.

*E. Regulatory Flexibility Act—
Departments of Labor and HHS*

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 et seq.) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

For purposes of the RFA, the Departments continue to consider a “small entity” to be an employee benefit plan with fewer than 100 participants. The basis for this definition is found in section 104(a)(2) of the act, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans that cover fewer than 100 participants. Pursuant to

the authority of section 104(a)(3), the Department has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b–10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants and satisfying certain other requirements.

Further, while some large employers may have small plans, in general small employers maintain most small plans. Thus, the Departments believe that assessing the impact of these final regulations on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business that is based on size standards promulgated by the Small Business Administration (13 CFR 121.201) pursuant to the Small Business Act (15 U.S.C. 631 et seq.). The Departments requested comment on the appropriateness of the size standard at the proposed rule phase and received no responses.

Because these final regulations impose no additional costs on employers or plans, the Departments believe that they do not have a significant economic impact on a substantial number of small entities. Accordingly, pursuant to section 605(b) of the RFA, the Departments hereby certify that these final regulations will not have a significant economic impact on a substantial number of small entities.

*F. Special Analyses—Department of the
Treasury*

For purposes of the Department of the Treasury it has been determined that this final rule is not a significant regulatory action as defined in Executive Order 12866, as supplemented by Executive Order 13563. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these final regulations, and, because these final regulations do not impose a collection of information on small entities, an analysis under the RFA is not required. Pursuant to section 7805(f) of the Code, the notice of

proposed rulemaking preceding these final regulations was submitted to the Small Business Administration for comment on its impact on small business.

G. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 et seq.), as well as Executive Order 12875, these final regulations do not include any federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, which may impose an annual burden of \$100 million adjusted for inflation since 1995.

H. Federalism

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by federal agencies in formulating and implementing policies that have “substantial direct effects” on the states, the relationship between the national government and states, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with state and local officials, and describe the extent of their consultation and the nature of the concerns of state and local officials in the preamble to the final regulation.

In the Departments’ view, the final regulations, by clarifying policy regarding certain expected benefits options that can be designed by employers to support their employees, will provide more certainty to employers and others in the regulated community as well as states and political subdivisions regarding the treatment of such arrangements under ERISA. Accordingly, the Departments will continue to affirmatively engage in outreach with officials of state and political subdivisions regarding excepted benefits and seek their input on any federalism implications that they believe may be presented.

I. Congressional Review Act

These final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C.

801 et seq.), which specifies that, before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information. These final regulations are being transmitted to Congress and the Comptroller General for review.

IV. Statutory Authority

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Public Law 104–191, 110 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Public Law 110–343, 122 Stat. 3765; Public Law 110–460, 122 Stat. 5123; Secretary of Labor’s Order 1–2011, 77 FR 1088 (January 9, 2012).

The Department of Health and Human Services regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 146

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

John M. Dalrymple,
*Deputy Commissioner for
Services and Enforcement
Internal Revenue Service*

Approved: March 11, 2015

Mark J. Mazur,
*Assistant Secretary of the
Treasury (Tax Policy)*

Signed this 11th day of March, 2015.

Phyllis C. Borzi,
*Assistant Secretary Employee
Benefits Security Administration
Department of Labor*

Dated: March 11, 2015.

Andrew M. Slavitt,
*Acting Administrator Centers
for Medicare & Medicaid Services*

Dated: March 11, 2015.

Sylvia Burwell,
*Secretary Department of
Health and Human Services*

DEPARTMENT OF THE TREASURY

Internal Revenue Service
26 CFR Chapter I

Accordingly, 26 CFR part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 continues to read in part as follows:

Authority: Authority: 26 U.S.C. 7805.
* * *

Section 54.9831–1 also issued under 26 U.S.C. 9833; * * *

Par 2. Section 54.9831–1 is amended by adding paragraph (c)(3)(vii) to read as follows:

§ 54.9831–1 Special rules relating to group health plans.

* * * * *
(c) * * *

(3) * * *

(vii) *Limited wraparound coverage.* Limited benefits provided through a group health plan that wrap around eligible individual health insurance (or Basic Health Plan coverage described in section 1331 of the Patient Protection and Affordable Care Act); or that wrap around coverage under a Multi-State Plan described in section 1334 of the Patient Protection and Affordable Care Act, collectively referred to as “limited wraparound coverage,” are excepted benefits if all of the following conditions are satisfied. For this purpose, eligible individual health insurance is individual health insurance coverage that is not a grandfathered health plan (as described in section 1251 of the Patient Protection and Affordable Care Act and 29 CFR 2590.715–1251), not a transitional individual health insurance plan (as described in the March 5, 2014 Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016), and does not consist solely of excepted benefits (as defined in paragraph (c) of this section).

(A) *Covers additional benefits.* The limited wraparound coverage provides meaningful benefits beyond coverage of cost sharing under either the eligible individual health insurance, Basic Health Program coverage, or Multi-State Plan coverage. The limited wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not consist of an account-based reimbursement arrangement.

(B) *Limited in amount.* The annual cost of coverage per employee (and any covered dependents, as defined in § 54.9801–2) under the limited wraparound coverage does not exceed the greater of the amount determined under either paragraph (c)(3)(vii)(B)(I) or (2) of this section. Making a determination regarding the annual cost of coverage per employee must occur on an aggregate basis relying on sound actuarial principles.

(I) The maximum permitted annual salary reduction contribution toward health flexible spending arrangements, indexed in the manner prescribed under section 125(i)(2). For this purpose, the cost of coverage under the limited wraparound includes both employer and employee contributions towards coverage and is de-

terminated in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(2) Fifteen percent of the cost of coverage under the primary plan. For this purpose, the cost of coverage under the primary plan and under the limited wraparound coverage includes both employer and employee contributions towards the coverage and each is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

(C) *Nondiscrimination.* All of the conditions of this paragraph (c)(3)(vii)(C) are satisfied.

(1) *No preexisting condition exclusion.* The limited wraparound coverage does not impose any preexisting condition exclusion, consistent with the requirements of section 2704 of the PHS Act (incorporated by reference into section 9815) and 29 CFR 2590.715–2704.

(2) *No discrimination based on health status.* The limited wraparound coverage does not discriminate against individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual, as defined in § 54.9801–2), consistent with the requirements of section 9802 and section 2705 of the PHS Act (incorporated by reference into section 9815).

(3) *No discrimination in favor of highly compensated individuals.* Neither the limited wraparound coverage, nor any other group health plan coverage offered by the plan sponsor, fails to comply with section 2716 of the PHS Act (incorporated by reference into section 9815) or fails to be excludible from income for any individual due to the application of section 105(h)(as applicable).

(D) *Plan eligibility requirements.* Individuals eligible for the wraparound coverage are not enrolled in excepted benefit coverage under paragraph (c)(3)(v) of this section (relating to health FSAs). In addition, the conditions set forth in either paragraph (c)(3)(vii)(D)(1) or (2) of this section are met.

(1) *Limited wraparound coverage that wraps around eligible individual insurance for persons who are not full-time employees.* Coverage that wraps around eligible individual health insurance (or that wraps around Basic Health Plan cov-

erage) must satisfy all of the conditions of this paragraph (c)(3)(vii)(D)(1).

(i) For each year for which limited wraparound coverage is offered, the employer that is the sponsor of the plan offering limited wraparound coverage, or the employer participating in a plan offering limited wraparound coverage, offers to its full-time employees coverage that is substantially similar to coverage that the employer would need to offer to its full-time employees in order not to be subject to a potential assessable payment under the employer shared responsibility provisions of section 4980H(a), if such provisions were applicable; provides minimum value (as defined in section 36B(c)(2)(C)(ii)); and is reasonably expected to be affordable (applying the safe harbor rules for determining affordability set forth in § 54.4980H–5(e)(2)). If a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose to the plan or issuer necessary information regarding their coverage offered and affordability information, the plan or issuer is permitted to rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary. In the event that the employer that is the sponsor of the plan offering wraparound coverage, or the employer participating in a plan offering wraparound coverage, has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(1)(i) is considered satisfied.

(ii) Eligibility for the limited wraparound coverage is limited to employees who are reasonably determined at the time of enrollment to not be full-time employees (and their dependents, as defined in § 54.9801–2), or who are retirees (and their dependents, as defined in § 54.9801–2). For this purpose, full-time employees are employees who are reasonably expected to work at least an average of 30 hours per week.

(iii) Other group health plan coverage, not limited to excepted benefits, is offered to the individuals eligible for the limited wraparound coverage. Only individuals eligible for the other group health plan coverage are eligible for the limited wraparound coverage.

(2) *Limited coverage that wraps around Multi-State Plan coverage.* Coverage that wraps around Multi-State Plan coverage must satisfy all of the conditions of this paragraph (c)(3)(vii)(D)(2). For this purpose, the term “full-time employee” means a “full-time employee” as defined in § 54.4980H–1(a)(21) who is not in a limited non-assessment period for certain employees (as defined in § 54.4980H–1(a)(26)). Moreover, if a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose to the plan or issuer necessary information regarding their coverage offered and contribution levels for 2013 or 2014 (as applicable), and for any year in which limited wraparound coverage is offered, the plan or issuer is permitted to rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary. Consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, the Office of Personnel Management may verify that plans and issuers have reasonable mechanisms in place to ensure that contributing employers meet these standards.

(i) The limited wraparound coverage is reviewed and approved by the Office of Personnel Management, consistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section, to provide benefits in conjunction with coverage under a Multi-State Plan authorized under section 1334 of the Patient Protection and Affordable Care Act. The Office of Personnel Management may revoke approval if it determines that continued approval is inconsistent with the reporting and evaluation criteria of paragraph (c)(3)(vii)(E) of this section.

(ii) The employer offered coverage in the plan year that began in either 2013 or 2014 that is substantially similar to coverage that the employer would need to have offered to its full-time employees in order to not be subject to an assessable payment under the employer shared responsibility provisions of section 4980H(a), if such provisions had been applicable. In the event that a plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the

requirement of this paragraph (c)(3)(vii)(D)(2)(ii) is considered satisfied.

(iii) In the plan year that began in either 2013 or 2014, the employer offered coverage to a substantial portion of full-time employees that provided minimum value (as defined in section 36B(c)(2)(C)(ii)) and was affordable (applying the safe harbor rules for determining affordability set forth in § 54.4980H-5(e)(2)). In the event that the plan that offered coverage in 2013 or 2014 has no full-time employees for any plan year limited wraparound coverage is offered, the requirement of this paragraph (c)(3)(vii)(D)(2)(iii) is considered satisfied.

(iv) For the duration of the pilot program, as described in paragraph (c)(3)(vii)(F) of this section, the employer's annual aggregate contributions for both primary and limited wraparound coverage are substantially the same as the employer's total contributions for coverage offered to full-time employees in 2013 or 2014.

(E) *Reporting – (1) Reporting by group health plans and group health insurance issuers.* A self-insured group health plan, or a health insurance issuer, offering or proposing to offer limited wraparound coverage in connection with Multi-State Plan coverage pursuant to paragraph (c)(3)(vii)(D)(2) of this section reports to the Office of Personnel Management (OPM), in a form and manner specified in guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements of this section.

(2) *Reporting by group health plan sponsors.* The plan sponsor of a group health plan offering limited wraparound coverage under paragraph (c)(3)(vii) of this section, must report to the Department of Health and Human Services (HHS), in a form and manner specified in guidance, information HHS reasonably requires.

(F) *Pilot program with sunset.* The provisions of paragraph (c)(3)(vii) of this section apply to limited wraparound coverage that is first offered no earlier than January 1, 2016 and no later than December 31, 2018 and that ends no later than on the later of:

(1) The date that is three years after the date limited wraparound coverage is first offered; or

(2) The date on which the last collective bargaining agreement relating to the plan terminates after the date limited wraparound coverage is first offered (determined without regard to any extension agreed to after the date limited wraparound coverage is first offered).

* * * * *

Section 42.—Low-Income Housing Credit

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 280G.—Golden Parachute Payments

Federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 382.—Limitation on Net Operating Loss Carryforwards and Certain Built-In Losses Following Ownership Change

The adjusted applicable federal long-term rate is set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 412.—Minimum Funding Standards

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 467.—Certain Payments for the Use of Property or Services

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 468.—Special Rules for Mining and Solid Waste Reclamation and Closing Costs

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 482.—Allocation of Income and Deductions Among Taxpayers

Federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 483.—Interest on Certain Deferred Payments

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 642.—Special Rules for Credits and Deductions

Federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 807.—Rules for Certain Reserves

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 846.—Discounted Unpaid Losses Defined

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015-7, page 849.

Section 1288.—Treatment of Original Issue Discount on Tax-Exempt Obligations

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015–7, page 849.

Section 7520.—Valuation Tables

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015–7, page 849.

Section 7872.—Treatment of Loans With Below-Market Interest Rates

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of April 2015. See Rev. Rul. 2015–7, page 849.

Part III. Administrative, Procedural, and Miscellaneous

Guidance on the Application of Code § 4980D to Certain Types of Health Coverage Reimbursement Arrangements

Notice 2015-17

I. PURPOSE AND OVERVIEW

This notice reiterates the conclusion in previous guidance addressing employer payment plans, including Notice 2013-54, 2013-40 I.R.B. 287,³² that employer payment plans are group health plans that will fail to comply with the market reforms that apply to group health plans under the Affordable Care Act (ACA).³³ For this purpose, an employer payment plan as described in Notice 2013-54 refers to a group health plan under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy or directly pays a premium for an individual health insurance policy covering the employee, such as arrangements described in Revenue Ruling 61-146, 1961-2 C.B. 25. This notice also provides transition relief from the assessment of excise tax under Internal Revenue Code (Code) § 4980D for failure to satisfy market reforms in certain circumstances. The transition relief applies to employer healthcare arrangements that constitute (1) employer payment plans, as described in Notice 2013-54, if the plan is sponsored by an employer that is not an Applicable Large Employer (ALE) under Code § 4980H(c)(2) and §§ 54.4980H-1(a)(4) and -2; (2) S corporation healthcare arrangements for 2-percent shareholder-em-

ployees;³⁴ (3) Medicare premium reimbursement arrangements; and (4) TRICARE-related health reimbursement arrangements (HRAs). This notice also provides additional guidance on the tax treatment of employer payment plans. This notice supplements and clarifies the guidance provided in Notice 2013-54 and other guidance in response to comments and questions from taxpayers and stakeholder groups about certain aspects of that guidance.

The United States Department of Labor (DOL) and the United States Department of Health and Human Services (HHS) (collectively with the Treasury Department and the IRS, the Departments) have reviewed this notice and have advised the Treasury Department and the IRS that they agree with the guidance provided in this notice.

The Treasury Department and the IRS anticipate that clarifications regarding other aspects of employer payment plans and HRAs will be provided in the near future. This notice is intended to provide further clarification of the guidance provided in Notice 2013-54 and other guidance and is intended to be read in conjunction with that guidance.

II. GUIDANCE

Question 1 (Transition Relief for Small Employers from the Code § 4980D Excise Tax): Small employers have in the past often offered their employees health coverage through arrangements that would constitute an employer payment plan as described in Notice 2013-54. If an employer offered coverage through such an arrangement, will the employer owe an excise tax under Code § 4980D?

Answer 1: In general, yes; however, this notice provides limited transition relief for coverage sponsored by an employer that is not an ALE under §§ 54.4980H-1(a)(4) and -2.

Notice 2013-54 concludes that the arrangements constituting employer payment plans as described in that notice fail to comply with the market reforms and may subject employers to the excise tax under Code § 4980D. At the same time, the Departments understand that some employers that had been offering health coverage through an employer payment plan may need additional time to obtain group health coverage or adopt a suitable alternative.

The SHOP Marketplace addresses many of the concerns of small employers. However, because the market is still transitioning and the transition by eligible employers to SHOP Marketplace coverage or other alternatives will take time to implement, this guidance provides that the excise tax under Code § 4980D will not be asserted for any failure to satisfy the market reforms by employer payment plans that pay, or reimburse employees for individual health policy premiums or Medicare part B or Part D premiums (1) for 2014 for employers that are not ALEs for 2014, and (2) for January 1 through June 30, 2015 for employers that are not ALEs for 2015. After June 30, 2015, such employers may be liable for the Code § 4980D excise tax.

For purposes of this Q&A-1, an ALE generally is, with respect to a calendar year, an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. See Code § 4980H(c)(2) and §§ 54.4980H-1(a)(4) and -2. For determining whether an

³²There have been four prior issuances on the topics addressed in this notice: (1) FAQs About Affordable Care Act Implementation (Part XI), issued on January 24, 2013 by DOL (<http://www.dol.gov/ebsa/faqs/faq-aca11.html>) and HHS (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html); (2) IRS Notice 2013-54 and DOL Technical Release 2013-03, issued on September 13, 2013; (3) IRS FAQ on Employer Healthcare Arrangements (<http://www.irs.gov/Affordable-Care-Act/Employer-Health-Care-Arrangements>); and (4) FAQs About Affordable Care Act Implementation (Part XXII), issued on November 6, 2014 by DOL (<http://www.dol.gov/ebsa/faqs/faq-aca22.html>) and HHS (<http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf>).

³³The "Affordable Care Act" or "ACA" refers to the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152), and as further amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10), Section 1001 of the ACA added new Public Health Service Act (PHS Act) §§ 2711-2719, Section 1563 of the ACA (as amended by ACA § 10107(b)) added Code § 9815(a) and Employee Retirement Income Security Act (ERISA) § 715(a) to incorporate the provisions of part A of title XXVII of the PHS Act into the Code and ERISA, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are §§ 2701 through 2728. Accordingly, these referenced PHS Act sections (i.e., the market reforms) are subject to shared interpretive jurisdiction by the Departments.

³⁴For purposes of S corporations, 2-percent shareholder generally means any person who owns more than 2 percent of the stock of the S corporation. See Code § 1372(b)(2).

entity was an ALE for 2014 and for 2015, an employer may determine its status as an applicable large employer by reference to a period of at least six consecutive calendar months, as chosen by the employer, during the 2013 calendar year for determining ALE status for 2014 and during the 2014 calendar year for determining ALE status for 2015, as applicable (rather than by reference to the entire 2013 calendar year and the entire 2014 calendar year, as applicable). See section IX.E of the preamble to the proposed regulations under § 4980H (78 FR 218, 238) (Jan. 2, 2013) and section XV.D.3 of the preamble to the final regulations under § 4980H (79 FR 8544, 8573) (Feb. 12, 2014).

Employers eligible for the relief described in this Q&A–1 that have employer payment plans are not required to file IRS Form 8928 (regarding failures to satisfy requirements for group health plans under chapter 100 of the Code, including the market reforms) solely as a result of having such arrangements for the period for which the employer is eligible for the relief. This relief does not extend to stand-alone HRAs or other arrangements to reimburse employees for medical expenses other than insurance premiums.

Question 2 (Treatment of S corporation healthcare arrangements for 2-percent shareholder-employees): IRS Notice 2008–1, 2008–2 I.R.B. 1, provides that if an S corporation pays for or reimburses premiums for individual health insurance coverage covering a 2-percent shareholder (as defined in Code § 1372(b)(2)), the payment or reimbursement is included in income but the 2-percent shareholder-employee may deduct the amount of the premiums under Code § 162(l), provided that all other eligibility criteria for deductibility under Code § 162(l) are satisfied. (This arrangement is referred to in this notice as a 2-percent shareholder-employee healthcare arrangement.) Is a 2-percent shareholder-employee healthcare arrangement subject to the market reforms?

Answer 2: The Departments are contemplating publication of additional guidance on the application of the market reforms to a 2-percent shareholder-employee healthcare arrangement. Until such guidance is issued, and in any event through the end of 2015, the excise tax

under Code § 4980D will not be asserted for any failure to satisfy the market reforms by a 2-percent shareholder-employee healthcare arrangement. Further, unless and until additional guidance provides otherwise, an S corporation with a 2-percent shareholder-employee healthcare arrangement will not be required to file IRS Form 8928 (regarding failures to satisfy requirements for group health plans under chapter 100 of the Code, including the market reforms) solely as a result of having a 2-percent shareholder-employee healthcare arrangement.

The guidance provided in this Q&A–2 (including the guidance provided in the preceding paragraph) does not apply to reimbursements of individual health insurance coverage with respect to employees of an S corporation who are not 2-percent shareholders (but see Q&A–1).

The Treasury Department and the IRS are also considering whether additional guidance is needed on the federal tax treatment of 2-percent shareholder-employee healthcare arrangements. However, unless and until additional guidance provides otherwise, taxpayers may continue to rely on Notice 2008–1 with regard to the tax treatment of arrangements described therein for all federal income and employment tax purposes. To the extent that a 2-percent shareholder is allowed both the deduction under Code § 162(l) and the premium tax credit under Code § 36B, Revenue Procedure 2014–41, 2014–33 I.R.B. 364, provides guidance on computing the deduction and the credit with respect to the 2-percent shareholder.

Code § 9831(a)(2) provides that the market reforms do not apply to a group health plan that has fewer than two participants who are current employees on the first day of the plan year. Accordingly, an arrangement covering only a single employee (whether or not that employee is a 2-percent shareholder-employee) generally is not subject to the market reforms whether or not such a reimbursement arrangement otherwise constitutes a group health plan. If an S corporation maintains more than one such arrangement for different employees (whether or not 2-percent shareholder-employees), however, all such arrangements are treated as a single arrangement covering more than

one employee so that the exception in Code § 9831(a)(2) does not apply. For this purpose, if both a non-2-percent shareholder employee of the S corporation and a 2-percent shareholder employee of the S corporation are receiving reimbursements for individual premiums, the arrangement would be considered a group health plan for more than one current employee. However, if an employee is covered under a reimbursement arrangement with other-than-self-only coverage (such as family coverage) and another employee is covered by that same coverage as a spouse or dependent of the first employee, the arrangement would be considered to cover only the one employee.

Question 3 (Integration of Medicare premium reimbursement arrangement and TRICARE-related HRA with a group health plan): If an employer offers to reimburse Medicare premiums for its active employees, does this arrangement create an employer payment plan under Notice 2013–54? If so, may the employer payment plan be integrated with another group health plan to satisfy the annual dollar limit and preventive services requirements? Similarly, does an arrangement under which an employer reimburses (or pays directly) some or all of medical expenses for employees covered by TRICARE constitute an HRA subject to the market reforms? If so, may the HRA be integrated with another group health plan to satisfy the annual dollar limit and preventive services requirements?

Answer 3: Medicare premium reimbursement arrangements. An arrangement under which an employer reimburses (or pays directly) some or all of Medicare Part B or Part D premiums for employees constitutes an employer payment plan, as described in Notice 2013–54, and if such an arrangement covers two or more active employees, is a group health plan subject to the market reforms. An employer payment plan may not be integrated with Medicare coverage to satisfy the market reforms because Medicare coverage is not a group health plan. However, an employer payment plan that pays for or reimburses Medicare Part B or Part D premiums is integrated with another group health plan offered by the employer for purposes of the annual dollar limit prohibi-

bition and the preventive services requirements if (1) the employer offers a group health plan (other than the employer payment plan) to the employee that does not consist solely of excepted benefits and offers coverage providing minimum value; (2) the employee participating in the employer payment plan is actually enrolled in Medicare Parts A and B; (3) the employer payment plan is available only to employees who are enrolled in Medicare Part A and Part B or Part D; and (4) the employer payment plan is limited to reimbursement of Medicare Part B or Part D premiums and excepted benefits, including Medigap premiums. Note that to the extent such an arrangement is available to active employees, it may be subject to restrictions under other laws such as the Medicare secondary payer provisions. An employer payment plan that has fewer than two participants who are current employees (for example, a retiree-only plan) on the first day of the plan year is not subject to the market reforms and, therefore, integration is not necessary to satisfy the market reforms.

TRICARE-related HRAs. Similarly, an arrangement under which an employer reimburses (or pays directly) some or all of medical expenses for employees covered by TRICARE constitutes an HRA, and, as provided in Notice 2013-54, if such an arrangement covers two or more active employees, is a group health plan subject to the market reforms. An HRA may not be integrated with TRICARE to satisfy the market reforms because TRICARE is not a group health plan for integration purposes. However, an HRA that pays for or reimburses medical expenses for employees covered by TRICARE is integrated with another group health plan offered by the employer for purposes of the annual dollar limit prohibition and the preventive services requirements if (1) the employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits and offers coverage providing minimum value; (2) the employee participating in the HRA is actually enrolled in TRICARE; (3) the HRA is available only to employees who are enrolled in TRICARE; and

(4) the HRA is limited to reimbursement of cost sharing and excepted benefits, including TRICARE supplemental premiums. Note that to the extent such an arrangement is available to active employees, employers should be aware of laws that prohibit offering financial or other incentives for TRICARE-eligible employees to decline employer-provided group health plan coverage, similar to the Medicare secondary payer rules.

Note that an employer may provide more than one type of healthcare arrangement for its employees (for example, a Medicare Part B employer payment plan and a TRICARE-related HRA), provided that each arrangement meets the applicable integration or other rules set forth in this notice or in related guidance.

Question 4 (Increases in employee compensation to assist with payments of individual market coverage): If an employer increases an employee's compensation, but does not condition the payment of the additional compensation on the purchase of health coverage (or otherwise endorse a particular policy, form, or issuer of health insurance), is this arrangement an employer payment plan?

Answer 4: No. As described in Notice 2013-54, an employer payment plan is a group health plan under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy or directly pays a premium for an individual health insurance policy covering the employee, such as arrangements described in Rev. Rul. 61-146. The arrangement described in this Q&A-4 does not meet that description. In addition, because the arrangement described in this Q&A-4 generally will not constitute a group health plan, it is not subject to the market reforms.³⁵ Providing employees with information about the Marketplace or the premium tax credit under Code § 36B is not endorsement of a particular policy, form, or issuer of health insurance.

Question 5 (Treatment of an employer payment plan as taxable compensation): Notice 2013-54 provides that the payment arrangement described in Rev. Rul. 61-146 is an employer payment plan. May the

reimbursements or payments under an arrangement described in Rev. Rul. 61-146 be provided on an after-tax basis and, if so, will this cause the arrangement not to be a group health plan (and accordingly not to be subject to the market reforms)?

Answer 5: No. Rev. Rul. 61-146 holds that under certain conditions, if an employer reimburses an employee's substantiated premiums for non-employer sponsored hospital and medical insurance, the payments are excluded from the employee's gross income under Code § 106. This exclusion also applies if the employer pays the premiums directly to the insurance company. The holding in Rev. Rul. 61-146 continues to apply, meaning only that payments under arrangements that meet the conditions set forth in Rev. Rul. 61-146 are excludable from the employee's gross income under Code § 106 (regardless of whether the employer includes the payments as wage payments on the Form W-2). However, Rev. Rul. 61-146 does not address the application of the market reforms and should not be read as containing any implication regarding the application of the market reforms. As explained in Notice 2013-54, an arrangement under which an employer provides reimbursements or payments that are dedicated to providing medical care, such as cash reimbursements for the purchase of an individual market policy, is itself a group health plan. Accordingly, the arrangement is subject to the market reform provisions of the Affordable Care Act applicable to group health plans without regard to whether the employer treats the money as pre-tax or post-tax to the employee. Such employer health care arrangements cannot be integrated with individual market policies to satisfy the market reforms and, therefore, will fail to satisfy PHS Act §§ 2711 (annual limit prohibition) and 2713 (requirement to provide cost-free preventive services) among other provisions.

III. FOR FURTHER INFORMATION

Questions concerning the information contained in this notice may be directed to the IRS at 202-317-6846. Additional information for employers regarding the Af-

³⁵For more information on establishing or maintaining a group health plan under ERISA, see 29 CFR 2510.3-1(j) and the Department of Labor's Field Assistance Bulletins Nos. 2006-2 and 2004-1, available at <http://www.dol.gov/ebsa/regs/fab2006-2.html> and <http://www.dol.gov/ebsa/regs/fab2004-1.html>.

fordable Care Act is available at www.healthcare.gov, www.dol.gov/ebsa/healthreform, and at www.business.usa.gov.

IV. DRAFTING INFORMATION

The principal author of this notice is Shad Fagerland of the Office of Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Mr. Fagerland at (202) 317-5500 (not a toll-free number).

Notice 2015-28

I. Extension of Temporary Nondiscrimination Relief for Closed Defined Benefit Plans

Notice 2014-5, 2014-2 I.R.B. 276, provides temporary nondiscrimination relief for certain “closed” defined benefit pension plans (i.e., defined benefit plans that provide ongoing accruals but that have been amended to limit those accruals to some or all of the employees who participated in the plan on a specified date). Specifically, for plan years beginning before 2016, Section III.B of Notice 2014-5 permits a DB/DC plan that includes a closed defined benefit plan (that was closed before December 13, 2013) and that satisfies certain conditions set forth in the notice to demonstrate satisfaction of the nondiscrimination in amount requirement of § 1.401(a)(4)-1(b)(2) on the basis of equivalent benefits even if the DB/DC plan does not meet any of the existing eligibility conditions for testing on that basis under § 1.401(a)(4)-9(b)(2)(v).

This notice extends the temporary nondiscrimination relief provided in Notice 2014-5 for an additional year by applying that relief to plan years beginning before 2017 if the conditions of Notice 2014-5 are satisfied. During the period for which this extension applies, the remaining provisions of the nondiscrimination regulations under § 401(a)(4) (including the rules relating to the timing of plan amendments under § 1.401(a)(4)-5) continue to apply.

The extension described in this notice is provided in anticipation of the issuance of proposed amendments to the § 401(a)(4) regulations that would be fi-

nalized and apply after the relief under Notice 2014-5 and this notice expires.

II. EFFECT ON OTHER DOCUMENTS

Notice 2014-5 is modified.

DRAFTING INFORMATION

The principal author of this notice is Kelly C. Scanlon of the Office of the Associate Chief Counsel (Tax Exempt and Government Entities). However, other personnel from the IRS participated in development of this guidance. For further information regarding this notice, please contact Ms. Scanlon or Linda Marshall at (202) 317-6700.

26 CFR 601.105: Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability.
(Also Part I, §§ 911; 1.911-1.)

Rev. Proc. 2015-25

SECTION 1. PURPOSE

.01 This revenue procedure provides information to any individual who failed to meet the eligibility requirements of section 911(d)(1) of the Internal Revenue Code because adverse conditions in a foreign country precluded the individual from meeting those requirements for taxable year 2014.

.02 This revenue procedure lists the countries for which the eligibility requirements of section 911(d)(1) are waived for taxable year 2014.

SECTION 2. BACKGROUND

.01 Sections 911(a) and (c)(4) of the Code allow a “qualified individual,” as defined in section 911(d) to exempt from taxation the individual’s foreign earned income and the housing cost amount.

.02 Section 911(d)(1) of the Code defines the term “qualified individual” as an individual whose tax home is in a foreign country and who is (A) a citizen of the United States and establishes to the satisfaction of the Secretary of the Treasury that the individual has been a *bona fide* resident of a foreign country or countries for an uninterrupted period that includes an entire taxable year, or (B) a citizen or

resident of the United States who, during any period of 12 consecutive months, is present in a foreign country or countries during at least 330 full days.

.03 Section 911(d)(4) of the Code provides an exception to the eligibility requirements of section 911(d)(1). An individual will be treated as a qualified individual with respect to a period in which the individual was a *bona fide* resident of, or was present in, a foreign country if the individual left the country during a period for which the Secretary of the Treasury, after consultation with the Secretary of State, determines that individuals were required to leave because of war, civil unrest, or similar adverse conditions that precluded the normal conduct of business. An individual must establish that but for those conditions the individual could reasonably have been expected to meet the eligibility requirements.

.04 For 2014, the Secretary of the Treasury, in consultation with the Secretary of State, has determined that war, civil unrest, or similar adverse conditions precluded the normal conduct of business in the following countries beginning on the specified date:

Country	Date of Departure on or after
Libya	July 26, 2014
Yemen	September 24, 2014

Accordingly, for purposes of section 911 of the Code, an individual who left one of the foregoing countries on or after the specified departure date during 2014 will be treated as a qualified individual with respect to the period during which that individual was present in, or was a *bona fide* resident of, such foreign country if the individual establishes a reasonable expectation of meeting the requirements of section 911(d) but for those conditions.

.05 To qualify for relief under section 911(d)(4) of the Code, an individual must have established residency, or have been physically present, in the foreign country on or prior to the date that the Secretary of the Treasury determines that individuals were required to leave the foreign country. Individuals who establish residency, or are first physically present, in the foreign country after the date that the Secretary

prescribes will not be treated as qualified individuals under section 911(d)(4) of the Code. For example, individuals who were first physically present or established residency in Libya after July 26, 2014, are not eligible to qualify for the exception provided in section 911(d)(4) of the Code for taxable year 2014.

SECTION 3. INQUIRIES

A taxpayer who needs assistance on how to claim this exclusion, or on how to file an amended return, should contact a local IRS Office or, for a taxpayer residing or traveling outside the United States, the nearest overseas IRS office.

SECTION 4. DRAFTING INFORMATION

The principal author of this revenue procedure is Kate Y. Hwa of the Office of Associate Chief Counsel (International). For further information regarding this rev-

enue procedure contact Kate Y. Hwa on (202) 317-6934 (not a toll free number).

Section 1274.— Determination of Issue Price in the Case of Certain Debt Instruments Issued for Property

(Also Sections 42, 280G, 382, 412, 467, 468, 482, 483, 642, 807, 846, 1288, 7520, 7872.)

Rev. Rul. 2015-7

This revenue ruling provides various prescribed rates for federal income tax purposes for April 2015 (the current month). Table 1 contains the short-term, mid-term, and long-term applicable federal rates (AFR) for the current month for purposes of section 1274(d) of the Internal Revenue Code. Table 2 contains the short-

term, mid-term, and long-term adjusted applicable federal rates (adjusted AFR) for the current month for purposes of section 1288(b). Table 3 sets forth the adjusted federal long-term rate and the long-term tax-exempt rate described in section 382(f). Table 4 contains the appropriate percentages for determining the low-income housing credit described in section 42(b)(1) for buildings placed in service during the current month. However, under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, with respect to housing credit dollar amount allocations made before January 1, 2015 shall not be less than 9%. Finally, Table 5 contains the federal rate for determining the present value of an annuity, an interest for life or for a term of years, or a remainder or a reversionary interest for purposes of section 7520.

REV. RUL. 2015-7 TABLE 1
Applicable Federal Rates (AFR) for April 2015

	<i>Period for Compounding</i>			
	<i>Annual</i>	<i>Semiannual</i>	<i>Quarterly</i>	<i>Monthly</i>
		<i>Short-term</i>		
AFR	.48%	.48%	.48%	.48%
110% AFR	.53%	.53%	.53%	.53%
120% AFR	.58%	.58%	.58%	.58%
130% AFR	.62%	.62%	.62%	.62%
		<i>Mid-term</i>		
AFR	1.70%	1.69%	1.69%	1.68%
110% AFR	1.87%	1.86%	1.86%	1.85%
120% AFR	2.04%	2.03%	2.02%	2.02%
130% AFR	2.21%	2.20%	2.19%	2.19%
150% AFR	2.56%	2.54%	2.53%	2.53%
175% AFR	2.98%	2.96%	2.95%	2.94%
		<i>Long-term</i>		
AFR	2.47%	2.45%	2.44%	2.44%
110% AFR	2.72%	2.70%	2.69%	2.68%
120% AFR	2.96%	2.94%	2.93%	2.92%
130% AFR	3.22%	3.19%	3.18%	3.17%

REV. RUL. 2015-7 TABLE 2

Adjusted AFR for April 2015

Period for Compounding

	<i>Annual</i>	<i>Semiannual</i>	<i>Quarterly</i>	<i>Monthly</i>
Short-term adjusted AFR	.40%	.40%	.40%	.40%
Mid-term adjusted AFR	1.37%	1.37%	1.37%	1.37%
Long-term adjusted AFR	2.47%	2.45%	2.44	2.44

REV. RUL. 2015-7 TABLE 3

Rates Under Section 382 for April 2015

Adjusted federal long-term rate for the current month	2.47%
Long-term tax-exempt rate for ownership changes during the current month (the highest of the adjusted federal long-term rates for the current month and the prior two months.)	2.47

REV. RUL. 2015-7 TABLE 4

Appropriate Percentages Under Section 42(b)(1) for April 2015

Note: Under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, with respect to housing credit dollar amount allocations made before January 1, 2015, shall not be less than 9%.

Appropriate percentage for the 70% present value low-income housing credit	7.48%
Appropriate percentage for the 30% present value low-income housing credit	3.21%

REV. RUL. 2015-7 TABLE 5

Rate Under Section 7520 for April 2015

Applicable federal rate for determining the present value of an annuity, an interest for life or a term of years, or a remainder or reversionary interest	2.0%
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Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as “rulings”) that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with modified, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A

and B, the prior ruling is modified because it corrects a published position. (Compare with amplified and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the sub-

stance of a prior ruling, a combination of terms is used. For example, modified and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.

ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel’s Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.

PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z—Corporation.

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¹A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2014–27 through 2014–52 is in Internal Revenue Bulletin 2014–52, dated December 28, 2014.

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¹A cumulative list of current actions on previously published items in Internal Revenue Bulletins 2014–27 through 2014–52 is in Internal Revenue Bulletin 2014–52, dated December 28, 2014.

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